Complete Summary

GUIDELINE TITLE

Cervical cancer screening for women who attend STD clinics or have a history of STDs. Sexually transmitted diseases treatment guidelines 2002.

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention. Cervical cancer screening for women who attend STD clinics or have a history of STDs. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10;51(RR-6):57-9.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Cervical cancer

GUIDELINE CATEGORY

Diagnosis
Management
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Oncology
Preventive Medicine

INTENDED USERS

Health Care Providers
Managed Care Organizations
Physicians

GUIDELINE OBJECTIVE(S)

- To update the 1998 Guidelines for Treatment of Sexually Transmitted Diseases (MMWR 1998;47[No. RR-1])
- To assist physicians and other health-care providers in preventing and treating sexually transmitted diseases (STDs)
- To present updated recommendations for cervical cancer screening for women who attend STD clinics or who have a history of STDs

TARGET POPULATION

Women who attend sexually transmitted disease (STD) clinics or who have a history of STDs

INTERVENTIONS AND PRACTICES CONSIDERED

Note from the National Guideline Clearinghouse and the Centers for Disease Control and Prevention: These guidelines focus on the treatment and counseling of individual patients and do not address other community services and interventions that are important in sexually transmitted disease/human immunodeficiency virus (STD/HIV) prevention.

1. Papanicolaou (Pap) test
2. Follow-up care
3. Colposcopy
4. Directed biopsy
5. Testing for human papillomavirus (HPV) DNA
6. Special considerations for pregnant women and women infected with HIV

MAJOR OUTCOMES CONSIDERED

- Risk for cervical cancer
- Prevalence of precursor lesions for cervical cancer
- Sensitivity of screening tests

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Beginning in 2000, Centers for Disease Control and Prevention (CDC) personnel and professionals knowledgeable in the field of sexually transmitted diseases (STDs) systematically reviewed literature (i.e., published abstracts and peer-reviewed journal articles) concerning each of the major STDs, focusing on information that had become available since publication of the 1998 Guidelines for Treatment of Sexually Transmitted Diseases. Background papers were written and tables of evidence constructed summarizing the type of study (e.g., randomized controlled trial or case series), study population and setting, treatments or other interventions, outcome measures assessed, reported findings, and weaknesses and biases in study design and analysis. A draft document was developed on the basis of the reviews.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Women with a history of (STD) may be at increased risk for cervical cancer, and women attending STD clinics may have other risk factors that place them at even greater risk. Prevalence studies have determined that precursor lesions for cervical cancer occur about five times more frequently among women attending STD clinics than among women attending family planning clinics. The cervical Papanicolaou (Pap) test is an effective, low-cost screening test for preventing invasive cervical cancer. Recommendations regarding Pap testing intervals vary in the United States. However, if a woman has three consecutive negative annual Pap tests, future screening tests may be performed less frequently.

Recommendations

At the time of a pelvic examination for STD screening, the health-care provider should inquire about the result of the patient's last Pap test and discuss the following information with the patient:

- the purpose and importance of a Pap test
- whether a Pap test was obtained during the clinic visit
- the need for a regular Pap test
- if a Pap test was not obtained during this examination, the names of local providers or referral clinics that can obtain Pap tests and adequately follow up results

If a woman has not had a Pap test during the previous 12 months, a Pap test may be obtained as part of the routine pelvic examination. Health-care providers should be aware that many women believe they have had a Pap test when they actually have received only a pelvic examination, and thus may report having had a recent Pap test. Therefore, in STD clinics, a Pap test should be strongly considered during the routine clinical evaluation of women who do not have clinical-record documentation of having had a normal Pap test within the preceding 12--36 months.

A woman may benefit from receiving printed information about Pap tests and a report containing a statement that a Pap test was obtained during her clinic visit. If possible, a copy of the Pap test result should be provided to the patient for her records.

Follow-Up

Clinicians who offer Pap test screening services are encouraged to use cytopathology laboratories that report results using the Bethesda System of classification.* If the results of the Pap test are abnormal, care should be provided according to the Interim Guidelines for Management of Abnormal Cervical Cytology published by the National Cancer Institute Consensus Panel (National Cancer Institute Workshop. The 1988 Bethesda System for reporting

cervical/vaginal cytological diagnoses. JAMA 1989;262:931-4). Appropriate follow-up of Pap tests showing high-grade squamous epithelial lesions (SIL) always includes referral to a clinician who can provide a colposcopic examination of the lower genital tract and, if indicated, colposcopically directed biopsy. For patients who have a Pap test indicative of low-grade SIL or atypical squamous cells of undetermined significance (ASCUS), follow-up without colposcopy may be acceptable in some circumstances. Such follow-up would involve repeat Pap tests every 4--6 months for 2 years until the results of three consecutive tests are negative. If repeat tests show persistent abnormalities, colposcopy and directed biopsy may be indicated. However, if compliance with follow-up is in question, women with low-grade SIL or ASCUS may be considered for colposcopy. If specific infections other than human papillomavirus (HPV) are identified, the patient should be reevaluated after appropriate treatment for those infections. In all follow-up strategies using repeat Pap tests, the tests not only must be negative but also must be interpreted by the laboratory as "satisfactory for evaluation". Tests determined by the laboratory to be "satisfactory but limited by..." in conjunction with a diagnosis of "negative" or "within normal limits" are also considered negative.

Another strategy for management of patients with ASCUS Pap tests involves testing for HPV deoxyribonucleic acid (DNA). If high-risk types of HPV DNA are detected, women with ASCUS tests are referred immediately for colposcopy. Because many public health clinics, including most STD clinics, cannot provide clinical follow-up of abnormal Pap tests, women with Pap tests demonstrating high grade SIL, persistent low-grade SIL, or ASCUS usually need a referral to other local health-care providers or clinics for colposcopy and biopsy. Clinics and health-care providers who offer Pap test screening services but cannot provide appropriate colposcopic follow-up of abnormal Pap tests should arrange referral to services in which a) a patient will be promptly evaluated and treated and b) the results of the evaluation will be reported to the referring clinic or health-care provider. Clinics and health-care providers should develop protocols that identify women who miss follow-up appointments so that these women can be scheduled for repeat Pap tests, and they should reevaluate such protocols routinely. Pap test results, type and location of follow-up appointments, and results of follow-up should be clearly documented in the clinic record. The establishment of colposcopy and biopsy services in local health departments, especially in circumstances where referrals are difficult and follow-up is unlikely, should be considered.

*The Bethesda System for Reporting Cervical/Vaginal Cytologic Diagnoses uses the term "low-grade squamous intraepithelial lesion (SIL)" and "high-grade SIL". Low-grade SIL encompasses cellular changes associated with human papillomavirus (HPV) and mild dysplasia/cervical intraepithelial neoplasia 1 (CIN1). High-grade SIL includes moderate dysplasia/CIN2, severe displasia/CIN3, and carcinoma in situ/CIN3.

Other Management Considerations

Other considerations in performing Pap tests are as follows.

- The Pap test is not a screening test for STDs.

- If a woman is menstruating, a Pap test should be postponed, and the woman should be advised to have a Pap test at the earliest opportunity.
- The presence of a mucopurulent discharge should not delay the Pap test. The test can be performed after careful removal of the discharge with a saline-soaked cotton swab.
- Women who have external genital warts do not need to have Pap tests more frequently than women who do not have warts, unless otherwise indicated.
- The sequence of Pap testing in relation to other cervicovaginal specimens does not appear to influence Pap test results or their interpretation. Therefore, when other cultures or specimens are collected for STD diagnoses, the Pap test can be obtained last.
- Women who have had a hysterectomy do not require a routine Pap test unless the hysterectomy was performed as a result of cervical cancer or its precursor lesions. In this situation, women should be advised to continue follow-up with the physician(s) who provided health care at the time of the hysterectomy.
- Health-care providers who receive basic retraining on Pap-test collection and clinics that use simple quality assurance measures obtain fewer unsatisfactory tests. The use of cytobrushes also improves the number of satisfactory Pap tests.
- Emerging data support the option of HPV testing for the triage of women who have ASCUS Pap tests. However, experience is limited and studies to define its value and cost-effectiveness are ongoing. The HPV testing strategy may be most cost-effective when conducted as "reflex testing", in which samples collected at the initial visit can be tested for HPV after the Pap test results are available. This approach requires the collection of a cervical swab placed in liquid media (i.e., liquid-based cytology or collection of a separate swab stored in HPV transport media).
- Liquid-based cytology is an alternative to conventional Pap tests. It has a higher sensitivity for detection of SIL and can facilitate HPV testing in women with ASCUS. However, it may also have a lower specificity, resulting in more false-positive tests and more administrative and patient-related costs, which could reduce the cost-effectiveness of cervical cancer screening.

Special Considerations

Pregnancy

Pregnant women should have a Pap test as part of routine prenatal care. A cytobrush may be used for obtaining Pap tests in pregnant women, although care should be taken not to disrupt the mucous plug.

Human Immunodeficiency Virus (HIV) Infection

Several studies have documented an increased prevalence of SIL in HIV-infected women. The following recommendations for Pap test screening among HIV-infected women are consistent with other guidelines published by the U.S. Department of Health and Human Services and are based partially on the opinions of professionals knowledgeable in the care and management of cervical cancer and HIV infection in women.

After obtaining a complete history of previous cervical disease, HIV-infected women should be provided a comprehensive gynecologic examination, including a pelvic examination and Pap test, as part of their initial evaluation. A Pap test should be obtained twice in the first year after diagnosis of HIV infection and, if the results are normal, annually thereafter. If the results of the Pap test are abnormal, care should be provided according to the Interim Guidelines for Management of Abnormal Cervical Cytology (National Cancer Institute Workshop. The 1988 Bethesda System for reporting cervical/vaginal cytological diagnoses. JAMA 1989;262:931-4). Women who have a cytological diagnosis of high-grade SIL or squamous cell carcinoma should undergo colposcopy and directed biopsy. HIV infection is not an indication for colposcopy in women who have normal Pap tests.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

Throughout the 2002 guideline document, the evidence used as the basis for specific recommendations is discussed briefly. More comprehensive, annotated discussions of such evidence will appear in background papers that will be published in a supplement issue of the journal Clinical Infectious Diseases.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Decreased morbidity and mortality from cervical cancer due to early detection and treatment

Subgroups Most Likely to Benefit:

Patients with human immunodeficiency virus (HIV) infection

POTENTIAL HARMS

Care should be taken not to disrupt the mucous plug when obtaining Papanicolaou (Pap) tests in pregnant women (a cytobrush may be used).

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These recommendations were developed in consultation with public- and private-sector professionals knowledgeable in the treatment of patients with sexually transmitted diseases (STDs). They are applicable to various patient-care settings, including family planning clinics, private physicians' offices, managed care organizations, and other primary-care facilities. When using these guidelines, the disease prevalence and other characteristics of the medical practice setting should be considered. These recommendations should be regarded as a source of clinical guidance and not as standards or inflexible rules. These guidelines focus on the treatment and counseling of individual patients and do not address other community services and interventions that are important in sexually transmitted disease/human immunodeficiency virus (STD/HIV) prevention.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention. Cervical cancer screening for women who attend STD clinics or have a history of STDs. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10;51(RR-6):57-9.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1993 (revised 2002 May 10)

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

GUIDELINE DEVELOPER COMMENT

These guidelines for the treatment of patients who have sexually transmitted diseases (STDs) were developed by the Centers for Disease Control and Prevention (CDC) after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta on September 26--28, 2000.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Chairpersons: David Atkins, M.D., M.P.H., Agency for Healthcare Research and Quality, Rockville, MD; Kimberly A. Workowski, M.D., Division of STD Prevention, CDC and Emory University, Atlanta, GA.

Presenters: Adaora A. Adimora, M.D., M.P.H., University of North Carolina, Chapel Hill, NC; Michael H. Augenbraun, M.D., State University of New York (SUNY) Health Science Center, Brooklyn, NY; Willard Cates, Jr., M.D., M.P.H., Family Health International, Research Triangle Park, NC; Jane Cecil, M.D., Johns Hopkins, Baltimore, MD; Lynne Fukumoto, UCLA School of Nursing, Los Angeles, CA; Margaret Hammerschlag, M.D., SUNY Health Science Center, Brooklyn, NY; Anne M. Rompalo, M.D., Johns Hopkins University, Baltimore, MD; Richard Rothenberg, M.D., Emory University School of Medicine, Atlanta, GA; Pablo J. Sanchez, M.D., University of Texas Southwestern Medical Center, Dallas, TX; Bradley Stoner, M.D., Ph.D., Washington University School of Medicine, St. Louis, MO; Jane R. Schwebke, M.D., Department of Medicine, University of Alabama, Birmingham, AL; Anna Wald, M.D., M.P.H., University of Washington, Seattle, WA; Cheryl K. Walker, M.D., Stanford University Medical Center, Stanford, CA; George D. Wendel, M.D., University of Texas Southwestern Medical Center, Dallas, TX; Karen Wendel, M.D., Johns Hopkins University, Baltimore, MD; Dorothy J. Wiley, Ph.D., UCLA School of Nursing, Los Angeles, CA; Jonathan M. Zenilman, M.D., Johns Hopkins University, Baltimore, MD.

Moderators: King K. Holmes, M.D., Ph.D., Center for AIDS and STDs, University of Washington, Seattle, WA; Edward W. Hook, III, M.D., University of Alabama, School of Medicine, Birmingham, AL; William McCormack, M.D., SUNY Health Science Center, Brooklyn, NY.

Rapporteurs: John M. Douglas, Jr., M.D., Denver Department of Public Health and University of Colorado Health Science Center, Denver, CO; H. Hunter Handsfield, M.D., University of Washington and Public Health-Seattle & King County, Seattle, WA; Walter Stamm, M.D., University of Washington Medical Center, Seattle, WA.

Consultants: Gail Bolan, M.D., California Dept. of Health, Berkeley, CA; Toye H. Brewer, M.D., University of Miami, Miami, FL; Virginia A. Caine, M.D., Indiana

University School of Medicine, Indianapolis, MN; Connie Celum, M.D., M.P.H., University of Washington, Seattle, WA; Myron S. Cohen, M.D., University of North Carolina, Chapel Hill, NC; Thomas A. Farley, M.D., M.P.H., Tulane University School of Public Health and Tropical Medicine, New Orleans, LA; Laura T. Gutman, M.D., Duke University, Durham, NC; Penelope J. Hitchcock, D.V.M., M.S., National Institute for Allergy and Infectious Diseases, NIH, Bethesda, MD; Sharon Hillier, Ph.D, Magee Women´s Hospital, Pittsburgh, PA; Franklyn N. Judson, M.D., Denver Department of Health, Denver, CO; David Martin, M.D., LSU Medical Center, New Orleans, LA; Daniel M. Musher, M.D., Veterans Affairs Medical Center, Houston, TX; Newton G. Osborne, M.D., M.P.H., Howard University Hospital, Washington, DC; Jeff Peipert, M.D., M.P.H., Women and Infants Hospital, Providence, RI; Peter Rice, M.D., Boston Medical Center, Boston, MA; Mary Sawyer, M.D., Emory University, Atlanta, GA; Jack Sobel, M.D., Wayne State University, Detroit, MI; David Soper, M.D., Medical University of South Carolina, Charleston, SC; Lawrence R. Stanberry, M.D., Ph.D., University of Texas Medical Branch, Galveston, TX; Barbara Stoll, M.D., Emory University School of Medicine, Atlanta, GA; Richard Sweet, M.D., Magee Women´s Hospital, Pittsburgh, PA; Eugene Washington, M.D., UCSF/Mt. Zion Medical Center, San Francisco, CA; Heather Watts, M.D., National Institutes of Health, Bethesda, MD.

Liaison Participants: Vagan A. Akovbian, M.D., Ph.D., Russian Ministry of Health Central Institute, Moscow, Russia; Gale Burstein, M.D., M.P.H, American Academy of Pediatrics; Willa Brown, M.D., M.P.H., American College of Preventative Medicine; Mike Catchpole, M.D., PHLS Communicable Disease Surveillance, England; Tom Cox, M.D., American Social Health Association; William Dumas, R.N., National Coalition of STD Directors; Antonio C. Gerbase, M.D., World Health Organization; Sharon Hillier, Ph.D., Infectious Disease Society of Obstetrics and Gynecology; Louella Klein, M.D., American College of Obstetrics and Gynecology; David J. Magid, M.D., M.P.H, Managed Care Colorado; Rafael Mazin, M.D., Pan American Health Organization; Gregory J. Moran, M.D., American College of Emergency Physicians; Donna Richmond, M.P.H., R.N., Association of Reproductive Health Professionals; Anthony Schaeffer, M.D., American Urological Association; Felicia Stewart, M.D., American Social Health Association; Stephen K. Tyring, M.D., Ph.D., American Academy of Dermatology; Leonard B. Weiner, M.D., American Academy of Pediatrics; Tom Wong, M.D., M.P.H., Health Canada.

CDC/Division of STD Prevention (DSTDP)/STD Treatment Guidelines 2002 Project Coordinators: Kimberly A. Workowski, M.D., DSTDP; William C. Levine, M.D., M.Sc., DSTDP.

Project Manager: Donald F. Dowda, DSTDP.

Co-Moderators: Lyn Finelli, Ph.D., DSTDP; Robert Johnson, M.D., DSTDP; Lauri Markowitz, M.D., DSTDP.

Presenters: Consuelo M. Beck-Sague, M.D., Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP); Jonathan E. Kaplan, M.D., DHAP/NCHSTP; Emilia Koumans, M.D., DSTDP; John Moran, M.D., DSTDP; Juliette Morgan, M.D., NCID; George P. Schmid, M.D., M.Sc, DSTDP; Madeline Sutton, M.D., DSTDP; Susan Wang, M.D, MPH, DSTDP.

Consultants: Sevgi O. Aral, Ph.D., DSTDP; Stuart M. Berman, M.D., DSTDP; Joanna Buffington, M.D., DVRD/NCID; Carol Ciesielski, M.D., DSTDP; George Counts, M.D., DSTDP; Julia Schillinger, M.D., M.Sc., DSTDP; Katherine Stone, M.D., DSTDP; Judith N. Wasserheit, M.D., M.P.H., DSTDP.

Support Staff: Valerie Barner, DSTDP; Garrett K. Mallory, DSTDP; Deborah McElroy, DSTDP; Porsha Williams, Contractor.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

The information in this report updates the "1998 Sexually Transmitted Diseases Treatment Guidelines" (MMWR 1998;47[No. RR-1]).

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- HTML version
- Portable Document Format (PDF)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Workowski KA, Levine WC, Wasserheit JN. U.S. Centers for Disease Control and Prevention guidelines for the treatment of sexually transmitted diseases: an opportunity to unify clinical and public health practice. Ann Intern Med. 2002 Aug 20;137(4):255-62. Electronic copies: Available through Annals of Internal Medicine Online.
- Sexually Transmitted Diseases Treatment Guidelines 2002 for PDA or Palm OS. Available from the CDC National Prevention Information Network (NPIN) Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on September 5, 2002.

Date Modified: 11/8/2004